STATE OF MARYLAND

DIRECT PAY ENROLLMENT FORM
JULY 2008-JUNE 2009 HEALTH BENEFITS

PERSONAL DATA *PLEASE PRINT CLEARLY*

EMPLOYEE'S/RETIREE'S INFORMATION

Name:
Address:
City **State** **Zip Code**

Home Phone: ( ) __ __ __- __ __ __ __
Work/Cell Phone: ( ) __ __ __ - __ __ __ __

Social Security Number: __ __ __ /__ __ / __ __ __ __

Date of Birth: ____/____/_____

Sex: ○ **Male** ○ **Female**

MARITAL STATUS:
○ Single ○ Widowed
○ Married ○ Divorced
○ Limited Divorce/Legal Separation

FORMER DEPENDENT'S INFORMATION
(if different from employee's information)

Name:
Address:
City **State** **Zip Code**

Home Phone: ( ) __ __ __- __ __ __ __
Work/Cell Phone: ( ) __ __ __ - __ __ __ __

Social Security Number: __ __ __ /__ __ / __ __ __ __

Date of Birth: ____/____/_____

Sex: ○ **Male** ○ **Female**

MARITAL STATUS:
○ Single ○ Widowed
○ Married ○ Divorced
○ Limited Divorce/Legal Separation

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

STATUS
○ COBRA Date of Qualifying Event: _____
Are you on Medicare? ○ Yes ○ No
○ Contractual – Contract Period: From: _____ To: _____
○ Part-Time Employee *(Less than 50%)*
○ LAW-MILITARY (Long Term Leave of Absence – Military)
Effective Date of LAW-MILITARY: _____
End Date of LAW-MILITARY: _____
○ LAW – PERSONAL (Long Term Leave of Absence Without Pay)
Effective Date of LAW-PERSONAL: _____
End Date of LAW-PERSONAL: _____
(May not exceed 2 years)
○ LAW-OJI (Long Term Leave of Absence – On the Job Injury)
Effective Date of LAW-OJI: _____
End Date of LAW-OJI: _____
(May not exceed 2 years)

ENROLLMENT/CHANGE ACTION REQUESTED
○ Open Enrollment
○ New Enrollment
○ Cancel All Coverage in All Plans
○ Change in Family Status (See Benefits Book for Documentation Requirements)
  ○ Add spouse/dependent because of:
    ○ Marriage Date: _____
    ○ Birth/Adoption/Appointed permanent legal guardian Date: _____
    ○ Other: _____
  ○ Remove spouse/dependent because of:
    ○ Divorce/Limited Divorce/Legal Separation Date: _____
    ○ Death Date: _____ *(Attach copy of Death Certificate)*
    ○ Dependent no longer eligible- explain: _____
    _____
    ○ Other: _____

Medical Benefits - Available to COBRA, LAW, Contractual, Part-Time

OPTIONS
○ New Enrollment or Change in Enrollment
○ Addition or removal of dependent
○ No, I do not want to start this benefit
○ Cancel current coverage

COVERAGE LEVEL
○ Individual Only
○ Individual & one child; name: _____
○ Individual & spouse
○ Individual & two or more
○ End Stage Renal (ESRD)

MEDICAL PLANS

PPO Plans:
○ BC/BS PPO
○ MLH Eagle PPO

HMO Plans:
○ BlueChoice HMO
○ Kaiser HMO
○ Optimum Choice HMO

POS Plans:
○ Aetna POS
○ BC/BS MD POS
○ MD IPA Preferred POS

NOTE: Vision and Mental Health/Substance Abuse benefits are available if enrolled in a medical plan. Medical plans do not include Prescription Drug or Dental coverage. See the following sections.

If you or a dependent have Medicare, write in name, Medicare number, effective date of Medicare coverage level.
Name _____ *Medicare Number* _____ *Date of Coverage* ___/____/_____
Name _____ *Medicare Number* _____ *Date of Coverage* ___/____/_____

ENROLLMENT FOR JULY 2008-JUNE 2009

Prescription Coverage - Available to COBRA, LAW, Contractual, Part-Time

OPTIONS
○ New enrollment
○ Addition or removal of dependent
○ No, I do not want to start this benefit
○ Cancel current coverage

COVERAGE LEVEL
○ Individual Only
○ Individual & one child; name:_____
○ Individual & spouse
○ Individual & two or more

Dental Coverage - Available to COBRA, LAW, Contractual, Part-Time

OPTIONS
○ New enrollment or change in plan
○ Addition or removal of dependent
○ No, I do not want to start this benefit
○ Cancel current coverage

COVERAGE LEVEL
○ Individual Only
○ Individual & one child; name:_____
○ Individual & spouse
○ Individual & two or more

DENTAL PLANS
Check only one dental plan:
1 ○ Dental Benefits Providers Dental HMO
2 ○ United Concordia Dental HMO
3 ○ United Concordia Dental PPO

Personal Accident and Dismemberment Benefits Available to LAW/Contractual/Part-Time Only

(NOT AVAILABLE TO COBRA ENROLLEES)

For Contractual/Part-Time Employees Only:

OPTIONS
○ New Enrollment or addition/removal of dependent
○ Change of benefit amount - select benefit amount
○ No, I do not want to start this benefit
○ Cancel current coverage

COVERAGE LEVEL
○ Employee only coverage
○ Family coverage

BENEFIT AMOUNT
○ $100,000
○ $200,000
○ $300,000

For Employees On LAW (Effective 7/1/2008)

○ I want to continue my coverage - select benefit amount
○ Cancel my coverage

Flexible Spending Accounts - Health Care

***For Employees Who Had Flexible Spending Accounts During Active Status In July 2008-June 2009 – Limited to COBRA Enrollees**

THIS IS NOT A PRE-TAX BENEFIT WHILE IN DIRECT PAY STATUS AND FUNDS MUST BE WITHDRAWN BY OCTOBER 15, 2009

Health Care Spending Account
○ I want to continue my Health Care Spending Account in July 2008-June 2009. I understand that I will be billed for the same total deduction amount as an active employee plus a 2% fee for COBRA enrollees.
○ Cancel my Health Care Spending Account. Expenses incurred prior to the cancellation day may be reimbursed up to the limit of your Health Care FSA.

ENROLLMENT FOR JULY 2008-JUNE 2009

Life Insurance - Available to LAW/Contractual/Part-Time Only

APPLICANT LIFE INSURANCE

For Contractual/Part-Time Employees Only:

○ Yes, I want to continue my July 2008-June 2009 level of coverage. Select benefit amount.
○ Yes, I want to continue my Life Insurance, but at a different coverage level. Select benefit amount.
○ Yes, I want to enroll as a new enrollee in Life Insurance. Select benefit amount.
○ No, I do not want to start this benefit
○ Cancel all Life Insurance (applicant and dependent)

Choose a Coverage Amount in increments of $10,000:

STOP-If you choose an amount greater than $50,000, you must fill out a Life Insurance Statement of Health for yourself. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for yourself.

Fill in the amount of Benefit

$ □ □ □ , ■ ■ ■

Coverage available in increments of $10,000 only

***For Employees on LAW:**

○ I want to continue my Life Insurance at the same $ value as an active employee. Select benefit amount.
○ No, I do not want to start this benefit
○ Cancel all Life Insurance (applicant and dependents)

DEPENDENT LIFE INSURANCE

For Contractual/Part-Time Employees Only:

Life Insurance on Spouse

○ Yes, I want to continue my spouse's life insurance at the July 2008-June 2009 level.
○ Yes, I want to continue my spouse's life insurance, but at a different amount. Select benefit amount.
○ Yes, I choose Dependent Life Insurance for my spouse. Select benefit amount.
○ No, I do not want to start this benefit.
○ Cancel Life Insurance on spouse.

Fill in the amount of Benefit

$ □ □ □ , ■ ■ ■

Spouse coverage available (up to 50% of employee's coverage) in increments of $5,000 only.

Life Insurance on Child(ren)

○ Yes, I want to continue my child(ren)'s life insurance at the July 2008-June 2009 level. Select benefit amount.
○ Yes, I want to continue my child(ren)'s life insurance, but at a different amount. Select benefit amount.
○ Yes, I want new life insurance on my child(ren). Select benefit amount.
○ No, I do not want to start this benefit.
○ Cancel Life Insurance on child(ren)

Fill in the amount of Benefit

$ □ □ □ , ■ ■ ■

Child coverage available (up to 50% of employee's coverage) in increments of $5,000 only.

If you choose an amount greater than $25,000, you must fill out a Life Insurance Statement of Health for your spouse or child. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for each covered spouse or child.

For Employees on LAW (Effective 7/1/2008-6/30/2009)

Continue Life Insurance on Spouse

○ I want to continue my Dependent Life Insurance on my spouse at the same benefit amount as in active status. (Select benefit amount above.)
○ Cancel Dependent Life Insurance on my spouse.

Continue Life Insurance for Child(ren)

○ I want to continue my Dependent Life Insurance on my child(ren) at the same benefit amount as in active status. (Select benefit amount above.)
○ Cancel Dependent Life Insurance on my child(ren).

ENROLLMENT FOR JULY 2008-JUNE 2009

COBRA - Consolidated Omnibus Budget Reconciliation Act

You and your eligible dependents may continue health coverage if the loss of coverage is due to one of the following qualifying events:

Mark the event that applies to you: **QUALIFYING EVENT**	**PERIOD OF TIME ELIGIBLE FOR CONTINUATION***
○ 1. Terminated employee (other than for gross misconduct)	18 months or until eligible for group coverage through another source including Medicare
○ 2. Resigned	18 months or until eligible for group coverage through another source including Medicare
○ 3. Laid off employee	18 months or until eligible for group coverage through another source including Medicare
○ 4. Employee whose hours have been involuntarily reduced	18 months or until eligible for group coverage through another source including Medicare
○ 5. Divorce or legally separated spouse of a current State employee/retiree	Indefinitely or at the time of remarriage or until eligible for group coverage through another source including Medicare
○ 6. Spouse of a State employee who has elected Medicare as the only coverage and the spouse is not eligible for Medicare	36 months or until eligible for group coverage through another source including Medicare
○ 7. Previously dependent child of an employee who is no longer eligible by reason of age, marriage, or death of employee	36 months or until eligible for group coverage through another source including Medicare
○ 8. Widowed spouse of a State employee/retiree	36 months or until eligible for group coverage through another source including Medicare

**** The period of continuation of coverage is the number of months listed, or until eligible for coverage elsewhere, whichever is less.***

LAW - Long Term Leave Without Pay

If the long term LAW is the result of a job-related accident or injury (LAW-OJI), the State will pay the State portion and the individual will pay the Active employee portion. A copy of the first report of injury form must be submitted with this enrollment form. If the long term LAW is due to any other reason, the individual must pay 100 percent of the premium. In either case the employee will be billed by the Department of Budget & Management for the amount due.

AGENCY BENEFITS COORDINATOR - PLEASE PRINT THE FOLLOWING:

A. _____ is on Approved Leave
Employee s Name

of Absence-On the Job Injury effective _____
Date

B. Anticipated date of return to work: _____
Date

C. Is this an initial LAW-OJI? ○ Yes ○ No **OR** Is this an extension of a previous Long Term LAW-OJI? ○ Yes ○ No

D. _____ _____
Agency Benefits Coordinator s Name (PRINT) Phone Number

_____
Agency

_____ _____ /_____ /_____
Agency Address Date

_____
Signature of Agency Benefits Coordinator or Appointing Authority

FISCAL OFFICER - PLEASE PRINT THE FOLLOWING:

Appropriation Code: ☐☐☐ ☐☐☐☐☐ ☐☐☐ ☐☐☐☐
Agency PCA TC R Stars Sub Object

_____ _____
Fiscal Officer Name & Phone Number Fiscal Officer Signature

ENROLLMENT FOR JULY 2008-JUNE 2009

Dependent Information

The following is reserved for dependent information. PLEASE PRINT. THIS MUST BE FILLED OUT COMPLETELY (INCLUDING SOCIAL SECURITY NUMBER AND DATE OF BIRTH) TO ENSURE YOUR DEPENDENTS ARE TRANSFERRED OVER TO THE PLANS FOR PROPER COVERAGE. You may use this section for additions (A), deletions (D), or changes (C) to your existing health benefits file for open enrollment or a qualifying event. Dependents include spouse and children.

A/C/D	LAST NAME	FIRST NAME	MI	SEX	BIRTH DATE	RELATIONSHIP	SOCIAL SECURITY NO.	COVER THIS DEPENDENT FOR: HEALTH	DRUG	DENTAL

NOTE: If you are adding or removing a dependent, please see your Benefits Book for dependent documentation requirements. Tax-qualified dependent children age 25 and over must be disabled prior to reaching age 25.

Applicant and Agency Signatures

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative before signing this application.

Please enroll me for the benefits indicated on this form. I understand the benefits and limitations provided by the various plans. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or to my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget & Management regulations. I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as the result of a qualifying change in status permitted by Section 125 of the Internal Revenue Code.

I understand that the Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen in this enrollment form are only in effect for July 2008-June 2009. The State of Maryland reserves the right to modify any benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond June 30, 2009. I certify that neither I nor my dependents are covered under another State of Maryland employee's or retiree's membership for any type of duplicate coverage.

I certify that I and the listed dependents are eligible for coverage. I understand that enrollment in benefits to which I am or my dependents are not entitled is considered fraud. In all cases I am responsible for the accuracy of my benefits, coverage levels and deductions. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my health benefits application, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be canceled, I will be required to repay any claims and insurance premiums, I may face charges for dismissal from State service, and I may face criminal investigation and prosecution.

Is there any other health insurance in which you, your spouse or any of your dependents are enrolled? ○ Yes ○ No

Specify who is covered, name of Insurance Company and Policy Number: _____

X _____
Your Signature

_____ /_____ /_____
Date

☐☐☐-☐☐☐-☐☐☐☐
Your Work/Cell Phone Number

X _____
AGENCY SIGNATURE - Agency Must Sign Here

_____ /_____ /_____
Date

☐☐☐-☐☐☐-☐☐☐☐
Work Phone Number (Ext.)

Agency Code: ☐☐☐☐☐☐

_____
Department

NOTE: This form must be completed in its entirety and appropriate documentation attached to be processed without delay.

COMPLETED AND SIGNED ENROLLMENT FORMS SHOULD BE MAILED OR HAND-DELIVERED TO:

Employee Benefits Division
Direct Pay Unit
301 W. Preston Street
Room 510
Baltimore, Maryland 21201

For Questions, Please Call:
(Monday - Friday 8:30 a.m. - 4:30 p.m.)
410-767-4775
1-800-307-8283

NOTE: LAW FORMS MUST BE SIGNED BY THE AGENCY BENEFITS COORDINATOR

Health Benefits information and forms are available on the Department of Budget and Management's website:
www.dbm.maryland.gov.
Select ***State Employees*** and ***Health Benefits.***